AUTHORIZATION TO RELEASE MEDICAL RECORDS

Upon presentation of the original or a photocopy of this signed authorization,

I, _____ , authorize

Name _____
Address _____
Address _____
City _____ State _____ Zip Code _____

(Name and address of institution or treating professional)

to provide information, including copies of records, concerning advice, care or treatment provided to me relating to

(1) hospitalization for treatment of a mental, emotional or nervous disorder or condition, or

(2) treatment for schizophrenia or other psychotic disorder, bipolar or major depressive mood disorder; drug or alcohol abuse; impulse control disorder, including kleptomania, pyromania, expolsive disorder, pathological or compulsive gambling; or paraphilia such as pedophilia, exhibitionism, or voyeurism

to the Connecticut Bar Examining Committee which is involved in conducting an investigation into my professional reputation and fitness for the practice of law.

I hereby release, discharge and exonerate the Connecticut Bar Examining Committee, its agents and representatives and the institution or treating professional named above so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Connecticut Bar Examining Committee.

_____
(Signature of applicant)

_____
(Date)

Subscribed and sworn to before

me this _____ day of

_____, 200__

_____
(Notary Public)